

# PATIENT INFORMATION

## PATIENT

Name \_\_\_\_\_  
 Address \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Apt. # \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 How long at this address? \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager ( ) \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Social Security # \_\_\_\_\_ DL# \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_\_

## RESPONSIBLE PARTY (If same as above, please skip)

Name \_\_\_\_\_  
 Address \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Apt. # \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 How long at this address? \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_  
 Age \_\_\_\_\_ Birthdate \_\_\_\_\_

## EMPLOYMENT

Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 How long? \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 Business Phone ( ) \_\_\_\_\_ Ext. # \_\_\_\_\_  
 Verified By \_\_\_\_\_ Date \_\_\_\_\_  
(Office use only)

## REFERENCES

Name \_\_\_\_\_  
 Address \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_  
 Spouses Name \_\_\_\_\_  
 Spouses Work # ( ) \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_

## PERSON TO CONTACT FOR EMERGENCY:

\_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_  
 \_\_\_\_\_  
Address  
 City \_\_\_\_\_ Zip \_\_\_\_\_ Tel # ( ) \_\_\_\_\_  
 Physician Name \_\_\_\_\_ Tel # ( ) \_\_\_\_\_

## GETTING TO KNOW YOU

Are there other members of your household who are not patients at our office  
 YES \_\_\_ NO \_\_\_ Please list names & relationship (son, daughter, husband) below:  
 1: \_\_\_\_\_ 2: \_\_\_\_\_  
 3: \_\_\_\_\_ 4: \_\_\_\_\_  
 How did you hear of us? \_\_\_\_\_  
 \_\_\_\_\_  
 Are you or anyone in your family a Union member? \_\_\_ YES \_\_\_ NO  
 If yes, specify Union/Local: \_\_\_\_\_  
 I want information in Spanish: \_\_\_ YES \_\_\_ NO

## REFERENCES

Primary Insurance Company  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, Zip \_\_\_\_\_  
 Insurance Co. Phone # \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Union/Local \_\_\_\_\_ Group # \_\_\_\_\_  
 Insured's Name \_\_\_\_\_  
 Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
**INSURANCE**  
 Secondary Insurance Company  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, Zip \_\_\_\_\_  
 Insurance Co. Phone # \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Union/Local \_\_\_\_\_ Group # \_\_\_\_\_  
 Insured's Name \_\_\_\_\_  
 Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_  
**MANAGED CARE PLAN (HMO)**  
 Plan Name \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Insured's Name \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_

1. I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.
2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by the authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that Bright Now! Dental provides business support services to independent dentists and recognize that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor Bright Now! Dental is responsible for my dental treatment.

\_\_\_\_\_  
 Signature of responsible party or patient  
 (Parent if patient is a minor)

\_\_\_\_\_  
 Date